

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03203

Reg. Dist. No.

3220

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HUGHESVILLE	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS ROUTE #1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PHYSICIANS MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HERBERT RAYMOND BOWMAN		4. DATE OF DEATH MARCH 29 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/86
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter (retired)		10b. KIND OF BUSINESS OR INDUSTRY Maintenance	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jack Bowman		14. MOTHER'S MAIDEN NAME Mary Quinter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW #1 578-07-9068	
17. INFORMANT Mr. Floyd J. Bowman, 3505 Anderson Rd. Kensington, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury	
20c. TIME OF INJURY Month, Day, Year Hour 6:00 p.m. 3-29 1958		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) WALDORF, CHARLES, MD.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE V. B. DETTOR		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) V. B. DETTOR, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/2/58	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE APR 2 '58		24b. REGISTRAR'S SIGNATURE W. E. Pumphrey	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 2 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03204

Reg. Dist. No.

3221

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rain View Village Indian Head</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Phy Mem Hosp</i>		d. STREET ADDRESS <i>Indian Head</i>	
3. NAME OF DECEASED (Type or print) <i>RAYMOND CHASTEEN COOK</i>		4. DATE OF DEATH <i>MARCH 11 1958</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 20 1915</i>
9. AGE (In years last birthday) <i>42 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <i>VA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Cook</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Janette Cook</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shock</i> <i>857X</i> DUE TO Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last. (b) <i>Crushing Injury of the Pelvis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>25 min.</i> <i>25 min.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Caught between the corners of two sand barges as they collided</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>3-12-58</i>	20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Work-Water</i>	20f. (City or town) (County) (State) <i>Greenway Flats, Charles, Maryland</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Vernon B. Dettor</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>March 12, 1958</i>	
EXAMINER'S NAME (Type) <i>VERNON B. DETTOR</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/14/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>McConfort</i>	22d. LOCATION (City, town, or county) (State) <i>Taylor, MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur T. McConfort</i>		24a. REC'D BY REGISTRAR <i>17 '58</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur T. McConfort</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
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BUREAU V. S.

MAR 17 1958

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CERTIFICATE OF DEATH

Reg. Dist. No.

03205

3222

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians' Memorial		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Joice Middle E Last Drinks		4. DATE OF DEATH Month March Day 26 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1958
9. AGE (In years last birthday) 2		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lester Drinks, Jr.		14. MOTHER'S MAIDEN NAME Joyce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Dr. Edelen Edelen LaPlata M.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Maternal Premature Separation of Placenta DUE TO (c) 3-1 days INTERVAL BETWEEN ONSET AND DEATH 2 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 26, 1958 , to March 26, 1958 , that I last saw the deceased alive on March 26, 1958 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Maryland DATE SIGNED 3-27-'58 ACTUAL SIGNATURE E. J. Edelen M.D. PHYSICIAN'S NAME (Type) E. J. Edelen, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-27-58	22c. NAME OF CEMETERY OR CREMATORY Wayside Episcopal Church Wayside Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Cerehart Inc LaPlata Md		24a. REC'D BY REGISTRAR DATE MAR 31 '58	24b. REGISTRAR'S SIGNATURE Edelen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3223

CERTIFICATE OF DEATH

Reg. Dist. No.

03206

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Arthur</u> Last <u>Estep</u>		4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 5, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Estep</u>		14. MOTHER'S MAIDEN NAME <u>Sidney Toye</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Jennie Toye</u>		Address <u>Hughesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Demethylated Carcinomatus</u> 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ca. of Esophagus</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 21, 1958</u> , to <u>March 21, 1958</u> , that I last saw the deceased alive on <u>3-21</u> , 19 <u>58</u> , and that death occurred at <u>11: A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H. Dabson</u> M.D.		ADDRESS (Street, city or town, state) <u>Brimleyville Md</u> DATE SIGNED <u>3-22-58</u>	
PHYSICIAN'S NAME (Type) <u>Richard H. Dabson</u>		<u>Brimleyville Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 24, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>	22d. LOCATION (City, town, or county) (State) <u>Bryantown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home Waldorf, Md</u>		24a. REC'D BY REGISTRAR <u>W. J. ...</u> 24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

MAR 26 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03207

3224

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Alton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Alton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>MARY E Fowler</i>		4. DATE OF DEATH <i>3 20 1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-20-70</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country) <i>Chasco, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Herbert Gibbons</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Jane Hatcher</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Oliver & Lyon Bel Alton Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>578x General Visceral Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1956-58</i>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>904.9. Fractured rt hip</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1956</i> , 19 <i>3-20</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>3-19</i> , 19 <i>58</i> , and that death occurred at <i>6 PM</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. J. Edelen</i> M.D.		DATE SIGNED <i>LaPlata, Md 3-20-58</i>	
PHYSICIAN'S NAME (Type) <i>R. J. EDELEN M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-20-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Ignations</i>		22d. LOCATION (City, town, or county) (State) <i>Open Hill Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Whehart Inc LaPlata Md</i>		24a. REC'D BY REGISTRAR <i>DATE MAR 26 '58</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Overhail</i>	

BUREAU V. S.

MAR 26 1958

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>				c. LENGTH OF STAY IN 1b <i>24 hours</i>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Clements</i>				d. STREET ADDRESS <i>18X-2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physician's Memorial Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>JOHN</i> Middle <i>Edward</i> Last <i>GUY</i>				4. DATE OF DEATH Month <i>MARCH</i> Day <i>8</i> Year <i>1958</i>			
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 19, 1871</i>	
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months <i>5</i> Days <i>17</i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>Jack Guy</i>				14. MOTHER'S MAIDEN NAME <i>Alice Mattingly</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Mrs Allison Robey</i> Address <i>Waldorf, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral Bronchopneumonia</i> <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO (c) <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pulmonary Emphysema and Chronic Bronchitis</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>No injury</i>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No injury</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	
20f. (City or town) <i></i>				20g. (County) <i></i>		20h. (State) <i></i>	
21. I certify that I attended the deceased from <i>5 March, 1958</i> to <i>8 March, 1958</i> , that I last saw the deceased alive on <i>8 March, 1958</i> , and that death occurred at <i>6:15 P.</i> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>V.B. Detton</i>				ADDRESS (Street, city or town, state) <i>Box 397</i> DATE SIGNED <i>8 March 1958</i>			
PHYSICIAN'S NAME (Type) <i>V.B. DETTON</i>				LA PLATA, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/12/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Joseph</i>		22d. LOCATION (City, town, or county) (State) <i>Morganza, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Clarke Mattingley</i>				ADDRESS <i>Leonardtwn, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 11 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03209

CERTIFICATE OF DEATH

Item 7 FilmG226 3-24-58 et

Reg. Dist. No.

1. PLACE OF DEATH 3226				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Newberg</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Newberg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>-Joseph</u> <u>Thomas</u> <u>Hill</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3</u> <u>11</u> <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 4, 1892</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>UNK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>UNK</u>				14. MOTHER'S MAIDEN NAME <u>UNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT & ADDRESS <u>Mary Yates, Newberg, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>433.1</u> IMMEDIATE CAUSE (A) <u>Acute Congestive Heart Failure</u>						<u>6 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Disease with</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Atrial Fibrillation</u>						<u>1 week</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-3</u>, 19<u>58</u>, to <u>3-11</u>, 19<u>58</u>, that I last saw the deceased alive on <u>3-10</u>, 19<u>58</u>, and that death occurred at <u>2:25 P</u>.M, from the causes and on the date stated above.							
SIGNATURE <u>Vernon B. Settor</u>				DATE SIGNED <u>3-12-'58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>3/15/58</u>		NAME OF CEMETERY OR CREMATORY <u>St Josephs</u>	
24. REC'D BY REGISTRAR <u>Mar 17 '58</u>				REGISTRAR'S SIGNATURE <u>One</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Walbert, Md.</u>	
DATE				ADDRESS <u>La Plata, Md.</u>			

CERTIFICATE OF DEATH

How Obtained

1. NAME - ADDRESS - PHONE NO. OF DECEASED

2. SEX - AGE - DATE OF BIRTH

3. PLACE OF BIRTH

4. OCCUPATION

5. CAUSE OF DEATH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF CLERK

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DEPUTY SHERIFF

18. SIGNATURE OF CONSTABLE

19. SIGNATURE OF ALDERMAN

20. SIGNATURE OF TOWNSHIP CLERK

21. SIGNATURE OF COUNTY CLERK

22. SIGNATURE OF STATE CLERK

23. SIGNATURE OF SECRETARY OF STATE

24. SIGNATURE OF COMMISSIONER OF HEALTH

25. SIGNATURE OF ASSISTANT COMMISSIONER

26. SIGNATURE OF CHIEF CLERK

27. SIGNATURE OF DEPUTY CHIEF CLERK

28. SIGNATURE OF CLERK IN CHARGE

BUREAU V. S.

MAR 17 1958

RECEIVED

RECEIVED

RECEIVED

3227

CERTIFICATE OF DEATH

Reg. Dist. No. 03210

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle JENNINGS Last JENNINGS				4. DATE OF DEATH Month Mar Day 3 Year 1958			
5. SEX M	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1920		9. AGE (In years last birthday) 37 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNK			14. MOTHER'S MAIDEN NAME UNK				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNK		16. SOCIAL SECURITY NO. 231 16 9722		17. INFORMANT Address Catherine Shirrel, Waldorf, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale 759.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cystic disease of the lung DUE TO (c) 3 years						INTERVAL BETWEEN ONSET AND DEATH 4 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 3-3 , 19 57 , to 3-3 , 19 58 , that I last saw the deceased alive on 3-3 , 19 58 , and that death occurred at 3:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE F. M. Johnson M.D.				ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 3-3-58			
PHYSICIAN'S NAME (Type) F. M. Johnson, M.D.				La Plata, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/58		22c. NAME OF CEMETERY OR CREMATORY Zion M.E.		22d. LOCATION (City, town, or county) (State) Waldorf, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home ADDRESS Waldorf, Md.				24a. REC'D BY REGISTRAR DATE MAR 10 58		24b. REGISTRAR'S SIGNATURE Qu. L. L. L.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH Home		2. SEX Male	
3. AGE 45		4. RACE White	
5. DATE OF DEATH March 10, 1958		6. TIME OF DEATH 10:00 AM	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural	
9. PLACE OF BIRTH Baltimore, Maryland		10. DATE OF BIRTH March 10, 1913	
11. NAME OF DECEASED John Doe		12. NAME OF NEXT OF KIN Jane Doe	
13. ADDRESS 123 Main St, Baltimore, MD		14. CITY Baltimore	
15. STATE Maryland		16. ZIP CODE 21201	
17. SIGNATURE OF DECEASED (None)		18. SIGNATURE OF NEXT OF KIN (None)	
19. SIGNATURE OF PHYSICIAN (None)		20. SIGNATURE OF CORONER (None)	
21. SIGNATURE OF REGISTRAR (None)		22. SIGNATURE OF CLERK (None)	

RECEIVED
MAR 10 1958
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3228

CERTIFICATE OF DEATH

Reg. Dist. No.

03211

1. PLACE OF DEATH o. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hosp.</u>				d. STREET ADDRESS <u>Brandynum</u> <u>16X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>S.</u> Last <u>KENRICK</u>				4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-5-1879</u>	
9. AGE (In years last birthday) yrs. <u>78</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WISCONSIN</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>BERNARD SCHWARTZ</u>			
14. MOTHER'S MAIDEN NAME <u>MARY SONNEBORN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u> </u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Collapse</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral vascular accident</u> DUE TO (c) <u>Arterio-sclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>9 days</u> <u>6 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>March</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 1</u> , 19 <u>58</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>LAPLATA</u> DATE SIGNED <u>2 Mar 58</u>							
ACTUAL SIGNATURE <u>Arthur Wooddy</u> M.D.				PHYSICIAN'S NAME (Type) <u>ARTHUR OVERTON WOODDY, M.D.</u> <u>MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>MARCH 6, 1958</u>		<u>Forest Home Cem</u>		<u>Forest Park, Ill.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold Funeral Home</u>				ADDRESS <u>Waldorf Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 5 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH		MANNER OF DEATH	
A. HOME		1. ACCIDENT	
B. HOSPITAL		2. SUICIDE	
C. OTHER		3. HOMICIDE	
D. PLACE OF BUSINESS		4. OTHER	
E. PLACE OF RECREATION		5. OTHER	
F. PLACE OF EDUCATION		6. OTHER	
G. PLACE OF EMPLOYMENT		7. OTHER	
H. PLACE OF TRAVEL		8. OTHER	
I. PLACE OF RESIDENCE		9. OTHER	
J. PLACE OF BIRTH		10. OTHER	
K. PLACE OF DEATH		11. OTHER	
L. PLACE OF DEATH		12. OTHER	
M. PLACE OF DEATH		13. OTHER	
N. PLACE OF DEATH		14. OTHER	
O. PLACE OF DEATH		15. OTHER	
P. PLACE OF DEATH		16. OTHER	
Q. PLACE OF DEATH		17. OTHER	
R. PLACE OF DEATH		18. OTHER	
S. PLACE OF DEATH		19. OTHER	
T. PLACE OF DEATH		20. OTHER	
U. PLACE OF DEATH		21. OTHER	
V. PLACE OF DEATH		22. OTHER	
W. PLACE OF DEATH		23. OTHER	
X. PLACE OF DEATH		24. OTHER	
Y. PLACE OF DEATH		25. OTHER	
Z. PLACE OF DEATH		26. OTHER	
AA. PLACE OF DEATH		27. OTHER	
AB. PLACE OF DEATH		28. OTHER	
AC. PLACE OF DEATH		29. OTHER	
AD. PLACE OF DEATH		30. OTHER	
AE. PLACE OF DEATH		31. OTHER	
AF. PLACE OF DEATH		32. OTHER	
AG. PLACE OF DEATH		33. OTHER	
AH. PLACE OF DEATH		34. OTHER	
AI. PLACE OF DEATH		35. OTHER	
AJ. PLACE OF DEATH		36. OTHER	
AK. PLACE OF DEATH		37. OTHER	
AL. PLACE OF DEATH		38. OTHER	
AM. PLACE OF DEATH		39. OTHER	
AN. PLACE OF DEATH		40. OTHER	
AO. PLACE OF DEATH		41. OTHER	
AP. PLACE OF DEATH		42. OTHER	
AQ. PLACE OF DEATH		43. OTHER	
AR. PLACE OF DEATH		44. OTHER	
AS. PLACE OF DEATH		45. OTHER	
AT. PLACE OF DEATH		46. OTHER	
AU. PLACE OF DEATH		47. OTHER	
AV. PLACE OF DEATH		48. OTHER	
AW. PLACE OF DEATH		49. OTHER	
AX. PLACE OF DEATH		50. OTHER	
AY. PLACE OF DEATH		51. OTHER	
AZ. PLACE OF DEATH		52. OTHER	
BA. PLACE OF DEATH		53. OTHER	
BB. PLACE OF DEATH		54. OTHER	
BC. PLACE OF DEATH		55. OTHER	
BD. PLACE OF DEATH		56. OTHER	
BE. PLACE OF DEATH		57. OTHER	
BF. PLACE OF DEATH		58. OTHER	
BG. PLACE OF DEATH		59. OTHER	
BH. PLACE OF DEATH		60. OTHER	
BI. PLACE OF DEATH		61. OTHER	
BJ. PLACE OF DEATH		62. OTHER	
BK. PLACE OF DEATH		63. OTHER	
BL. PLACE OF DEATH		64. OTHER	
BM. PLACE OF DEATH		65. OTHER	
BN. PLACE OF DEATH		66. OTHER	
BO. PLACE OF DEATH		67. OTHER	
BP. PLACE OF DEATH		68. OTHER	
BQ. PLACE OF DEATH		69. OTHER	
BR. PLACE OF DEATH		70. OTHER	
BS. PLACE OF DEATH		71. OTHER	
BT. PLACE OF DEATH		72. OTHER	
BU. PLACE OF DEATH		73. OTHER	
BV. PLACE OF DEATH		74. OTHER	
BW. PLACE OF DEATH		75. OTHER	
BX. PLACE OF DEATH		76. OTHER	
BY. PLACE OF DEATH		77. OTHER	
BZ. PLACE OF DEATH		78. OTHER	
CA. PLACE OF DEATH		79. OTHER	
CB. PLACE OF DEATH		80. OTHER	
CC. PLACE OF DEATH		81. OTHER	
CD. PLACE OF DEATH		82. OTHER	
CE. PLACE OF DEATH		83. OTHER	
CF. PLACE OF DEATH		84. OTHER	
CG. PLACE OF DEATH		85. OTHER	
CH. PLACE OF DEATH		86. OTHER	
CI. PLACE OF DEATH		87. OTHER	
CJ. PLACE OF DEATH		88. OTHER	
CK. PLACE OF DEATH		89. OTHER	
CL. PLACE OF DEATH		90. OTHER	
CM. PLACE OF DEATH		91. OTHER	
CN. PLACE OF DEATH		92. OTHER	
CO. PLACE OF DEATH		93. OTHER	
CP. PLACE OF DEATH		94. OTHER	
CQ. PLACE OF DEATH		95. OTHER	
CR. PLACE OF DEATH		96. OTHER	
CS. PLACE OF DEATH		97. OTHER	
CT. PLACE OF DEATH		98. OTHER	
CU. PLACE OF DEATH		99. OTHER	
CV. PLACE OF DEATH		100. OTHER	

RECEIVED
MAY 5 1938
BUREAU V. S.

3229

CERTIFICATE OF DEATH

03212

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Chas.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Chas</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata. Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>The Line</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physician's Home</u>		d. STREET ADDRESS <u>1 Kosh Point</u>	
3. NAME OF DECEASED (Type or print) <u>Bennie</u> First Middle Last <u>PHILLIPS</u>		4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Female.</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H W</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>J. Sitzer</u>		14. MOTHER'S MAIDEN NAME <u>Isabell Carter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>312-149495</u>	
17. INFORMANT Address <u>Harriette Venev. Rockpoint Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Collapse.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Cardio-vascular disease</u> DUE TO (c) <u>Senile Generalized.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec</u> , 1957, to <u>10 Mar</u> , 1958, that I last saw the deceased alive on <u>10 Mar</u> , 1958, and that death occurred at <u>7:45 A.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Arthur O. Woody</u> M.D. <u>La Plata.</u>		<u>10 Mar 58.</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOODY</u>		<u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Buried</u>	<u>3-10-58</u>	<u>Mt Zion</u>	<u>Downings Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<u>Richard Mc Le Plote Md</u>		DATE <u>MAR 17 '58</u>	<u>Red Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

22

BUREAU

MAR 17 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03213**

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nanjemoy</i> c. LENGTH OF STAY IN 1b <i>2 yr</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nanjemoy</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Patricia Ann Richmond</i>		4. DATE OF DEATH Month <i>March</i> Day <i>2</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 20, 1958</i>
9. AGE (In years last birthday) yrs. <i>1</i> Months <i>10</i> Days <i>10</i> Hours <i></i> Min. <i></i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Bobby Lee Richmond</i>	
14. MOTHER'S MAIDEN NAME <i>Violet Nichols</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Bobby L Richmond Nanjemoy Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Unknown</i> DUE TO (b) <i>795.5</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.			
ACTUAL SIGNATURE <i>E. J. Edelen</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. J. EDELEN M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>3-2-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>3-4-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Nanjemoy Baptist</i>		22d. LOCATION (City, town, or county) <i>Nanjemoy</i>	
(State) <i>Md</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur E. DePlata</i>	
ADDRESS		24a. REC'D BY REGISTRAR	
DATE <i>MAR 7 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. DePlata</i>	

2033162XV4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
DISEASE OR INJURY		SYMPTOMS		TREATMENT		POST-MORTEM		OTHER	
SIGNATURE OF EXAMINER		DATE		PLACE		TIME		OTHER	

BUREAU V. S.

MAR 7 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3231

CERTIFICATE OF DEATH

Reg. Dist. No.

03214

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Point</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Cecelia Marie Stine</u> First Middle Last		4. DATE OF DEATH <u>March 16</u> Month Day Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 2 1877</u> 9. AGE (In years last birthday) <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>St Marys Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lacey</u>		14. MOTHER'S MAIDEN NAME <u>Cecelia Quade</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>451X</u>	
17. INFORMANT <u>Raymond A Stine</u> Address <u>Rock Point Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissecting Aortic Aneurysm</u> DUE TO <u>451X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aortic Aneurysm, Saccular</u> DUE TO <u>1 year</u> (c) <u>Arteriosclerosis</u> DUE TO <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8 March</u> , 19 <u>58</u> to <u>16 March</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8 March</u> , 19 <u>58</u> , and that death occurred at <u>4:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J B Detton</u>		ADDRESS (Street, city or town, state) <u>La Plata, Maryland</u> DATE SIGNED <u>3/16/58</u>	
PHYSICIAN'S NAME (Type) <u>V. B. DETTOR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-18-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>		22d. LOCATION (City, town, or county) (State) <u>22nd Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. LaPlata</u> ADDRESS <u>Md</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 19 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Robert H. LaPlata</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
MAYNARD		45		M		W		1888		BALTIMORE		BALTIMORE		MARYLAND	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
MAY 19 1938		BALTIMORE		BALTIMORE		MARYLAND		MAY 19 1938		BALTIMORE		BALTIMORE		MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SPECIAL INSTRUCTIONS	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		2			
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
MAY 19 1938		BALTIMORE		BALTIMORE		MARYLAND		MAY 19 1938		BALTIMORE		BALTIMORE		MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SPECIAL INSTRUCTIONS	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		2			

BUREAU V. S.

MAR 19 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3232

CERTIFICATE OF DEATH

Reg. Dist. No.

03215

1. PLACE OF DEATH o. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Faulkner</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Faulkner</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>HENRY H SWANN</i>		4. DATE OF DEATH Month <i>3</i> Day <i>22</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 2, 1872</i>
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frank Swann</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Thompson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>James Swann</i>		Address <i>Clinton, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio vascular renal disease</i> <i>442x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>1957</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1947</i> , 19 <i>3-22-58</i> , that I last saw the deceased alive on <i>3-22-58</i> , and that death occurred at <i>8:30</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Edelen</i> M.D.		ADDRESS (Street, city or town, state) <i>La Plata Md</i> DATE SIGNED <i>3-24-58</i>	
PHYSICIAN'S NAME (Type) <i>J. EDELEN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/26/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Ignatius</i>	22d. LOCATION (City, town, or county) (State) <i>Bel Alton, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>HUNT Funeral Home</i>		ADDRESS <i>Waldorf, Md.</i>	
24a. REC'D BY REGISTRAR <i>W. Beach</i>		DATE <i>MAR 27 '58</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Back

1. PLACE OF BIRTH		2. NAME OF DECEASED	
3. SEX		4. AGE	
5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH	
9. PLACE OF DEATH		10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESS		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF CLERK		14. SIGNATURE OF REGISTRAR	
15. SIGNATURE OF JUDGE		16. SIGNATURE OF SHERIFF	
17. SIGNATURE OF CORONER		18. SIGNATURE OF JURY	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF COUNTY CLERK	
21. SIGNATURE OF STATE CLERK		22. SIGNATURE OF SECRETARY	
23. SIGNATURE OF ASSISTANT SECRETARY		24. SIGNATURE OF CHIEF CLERK	
25. SIGNATURE OF DEPUTY CLERK		26. SIGNATURE OF RECORDS CLERK	
27. SIGNATURE OF FILE CLERK		28. SIGNATURE OF INDEX CLERK	
29. SIGNATURE OF STENOGRAPHER		30. SIGNATURE OF TYPESETTER	
31. SIGNATURE OF PRINTER		32. SIGNATURE OF BINDER	
33. SIGNATURE OF DISTRIBUTOR		34. SIGNATURE OF CARRIER	
35. SIGNATURE OF COLLECTOR		36. SIGNATURE OF DELIVERER	
37. SIGNATURE OF READER		38. SIGNATURE OF REVIEWER	
39. SIGNATURE OF EDITOR		40. SIGNATURE OF PUBLISHER	
41. SIGNATURE OF MANAGER		42. SIGNATURE OF ASSISTANT MANAGER	
43. SIGNATURE OF GENERAL MANAGER		44. SIGNATURE OF SPECIAL MANAGER	
45. SIGNATURE OF CHIEF OF BUREAU		46. SIGNATURE OF DEPUTY CHIEF OF BUREAU	
47. SIGNATURE OF ASSISTANT CHIEF OF BUREAU		48. SIGNATURE OF CHIEF OF DIVISION	
49. SIGNATURE OF DEPUTY CHIEF OF DIVISION		50. SIGNATURE OF CHIEF OF SECTION	
51. SIGNATURE OF DEPUTY CHIEF OF SECTION		52. SIGNATURE OF CHIEF OF UNIT	
53. SIGNATURE OF DEPUTY CHIEF OF UNIT		54. SIGNATURE OF CHIEF OF OFFICE	
55. SIGNATURE OF DEPUTY CHIEF OF OFFICE		56. SIGNATURE OF CHIEF OF BRANCH	
57. SIGNATURE OF DEPUTY CHIEF OF BRANCH		58. SIGNATURE OF CHIEF OF DIVISION	
59. SIGNATURE OF DEPUTY CHIEF OF DIVISION		60. SIGNATURE OF CHIEF OF SECTION	
61. SIGNATURE OF DEPUTY CHIEF OF SECTION		62. SIGNATURE OF CHIEF OF UNIT	
63. SIGNATURE OF DEPUTY CHIEF OF UNIT		64. SIGNATURE OF CHIEF OF OFFICE	
65. SIGNATURE OF DEPUTY CHIEF OF OFFICE		66. SIGNATURE OF CHIEF OF BRANCH	
67. SIGNATURE OF DEPUTY CHIEF OF BRANCH		68. SIGNATURE OF CHIEF OF DIVISION	
69. SIGNATURE OF DEPUTY CHIEF OF DIVISION		70. SIGNATURE OF CHIEF OF SECTION	
71. SIGNATURE OF DEPUTY CHIEF OF SECTION		72. SIGNATURE OF CHIEF OF UNIT	
73. SIGNATURE OF DEPUTY CHIEF OF UNIT		74. SIGNATURE OF CHIEF OF OFFICE	
75. SIGNATURE OF DEPUTY CHIEF OF OFFICE		76. SIGNATURE OF CHIEF OF BRANCH	
77. SIGNATURE OF DEPUTY CHIEF OF BRANCH		78. SIGNATURE OF CHIEF OF DIVISION	
79. SIGNATURE OF DEPUTY CHIEF OF DIVISION		80. SIGNATURE OF CHIEF OF SECTION	
81. SIGNATURE OF DEPUTY CHIEF OF SECTION		82. SIGNATURE OF CHIEF OF UNIT	
83. SIGNATURE OF DEPUTY CHIEF OF UNIT		84. SIGNATURE OF CHIEF OF OFFICE	
85. SIGNATURE OF DEPUTY CHIEF OF OFFICE		86. SIGNATURE OF CHIEF OF BRANCH	
87. SIGNATURE OF DEPUTY CHIEF OF BRANCH		88. SIGNATURE OF CHIEF OF DIVISION	
89. SIGNATURE OF DEPUTY CHIEF OF DIVISION		90. SIGNATURE OF CHIEF OF SECTION	
91. SIGNATURE OF DEPUTY CHIEF OF SECTION		92. SIGNATURE OF CHIEF OF UNIT	
93. SIGNATURE OF DEPUTY CHIEF OF UNIT		94. SIGNATURE OF CHIEF OF OFFICE	
95. SIGNATURE OF DEPUTY CHIEF OF OFFICE		96. SIGNATURE OF CHIEF OF BRANCH	
97. SIGNATURE OF DEPUTY CHIEF OF BRANCH		98. SIGNATURE OF CHIEF OF DIVISION	
99. SIGNATURE OF DEPUTY CHIEF OF DIVISION		100. SIGNATURE OF CHIEF OF SECTION	

BUREAU V. B.

MAR 27 1958

RECEIVED

1

INSTRUCTIONS

TO ATTEND PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M-

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3233

CERTIFICATE OF DEATH

03216

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Indian Head Md</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Indian Head Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural give location) <u>Rt. 1-Bx-4 Indian Head Md</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Lawrence Surell Weeks</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3 5 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W-US</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5-9-1869</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Prince William County Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. Geo. Shelton Sr. Indian Head Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1. IMMEDIATE CAUSE (A) <u>420.1 Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>General Arterio-Sclerosis</u>						<u>Indefinite</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Senility</u>						<u>Indefinite</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-1-56</u>, 19....., to <u>3-5-58</u>, 19....., that I last saw the deceased alive on <u>3-5-58</u>, 19....., and that death occurred at <u>6:30 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>James E. Andrews</u>				ADDRESS (Street, city, town, state) <u>Indian Head Md</u>			
DATE SIGNED <u>3-6-58</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/8/58</u>		NAME OF CEMETERY OR CREMATORY <u>M.E. Disgah</u>		LOCATION (City, town, or county) (State) <u>Md</u>	
24. REC'D BY REGISTRAR <u>MAR 10 '58</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT Funeral Home</u>		ADDRESS <u>Walter, Md</u>	

CERTIFICATE OF DEATH

Block 1000-100

1. LOCAL RESIDENCE (HOUSE NO. & STREET)

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. AGE

9. OCCUPATION

10. MARITAL STATUS

11. EDUCATION

12. RELIGION

13. BIRTH DATE

14. BIRTH PLACE

15. BIRTH TIME

16. BIRTH WEIGHT

17. BIRTH LENGTH

18. BIRTH HEAD CIRCUMFERENCE

19. BIRTH SKIN COLOR

20. BIRTH HAIR COLOR

21. BIRTH EYE COLOR

22. BIRTH BUILD

23. BIRTH DENTAL RECORD

24. BIRTH VACCINATION RECORD

25. BIRTH MEDICAL RECORD

26. BIRTH SURGICAL RECORD

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